Ptarmigan Connections
3505 E Meridian Park Lp, Ste 200, Wasilla, AK 99654
907-357-4400 (ph)
907-357-4533 (fax)

Authorization to Release Report

☐ ***FASD*** ☐ ***Neuropsychological*** ☐ ***Other***

Child's Name: _____ Date of Birth: _____

By signing this authorization, I authorize Ptarmigan Connections to release report to:

☐ Parents: _____ Phone # _____

☐ Email_____ ☐ Pickup ☐ Fax_____ ☐ Mail _____

☐ Primary Care Provider: _____

☐ Email_____ ☐ Pickup ☐ Fax_____ ☐ Mail _____

☐ School: _____

☐ Email_____ ☐ Pickup ☐ Fax_____ ☐ Mail _____

☐ Psychology/Counseling: _____

☐ Email_____ ☐ Pickup ☐ Fax_____ ☐ Mail _____

☐ OT/ST/PT: _____

☐ Email_____ ☐ Pickup ☐ Fax_____ ☐ Mail _____

☐ Other (please list):_____

☐ Email_____ ☐ Pickup ☐ Fax_____ ☐ Mail _____

LEGAL NOTIFICATIONS Minors Only: A minor patient's signature is required to release the following specific information. Conditions relating to productive care including, but not limited to, birth control and pregnancy related services and sexually transmitted diseases, including HIV/AIDS (pertains to minors age 14 and older). • Substance Abuse diagnosis or treatment and mental health conditions (age 13 and older).

Minor Patient Signature: _____ Date Signed: _____

I understand that this authorization expires **one year** from the date the form is signed, unless I submit a written request to the clinic prior to that date. I understand that a revocation is not effective to the extent that information has already been used or disclosed in reliance on this Authorization. I understand that information used or disclosed pursuant to this Authorization may be used or disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name of Parent or Legal Guardian (circle one): _____

Signature of Parent or Legal Guardian (circle one): _____ Date: _____

Parent/guardian will be provided a signed copy of this form upon request. Updated 12/2/21